Decatur County Health Department
Prevent. Promote. Protect.

FOOD SERVICE APPLICATION FORM

Decatur County Health Department
801 N. Lincoln Street
Greensburg IN 47240
(812)663-8301 Fax (812)663-4174

Please send this form along with your payment on or before January 1, 2014. If you are requesting tax exempt status, please submit a copy of your 501 c 3. Fill out this form as you want it to appear on your permit. **An incomplete form will not be processed for a permit**. A **late fee** may be assessed at $20 for every 45 days in addition to the permit fee. Please enclose a copy of your entire menu. ***Permits are $40 for all Bed and Breakfast, Retail Food and Mobile Permits.***

Facility Name (As it will appear on permit)		Phone ( )_____ Fax ( )_____
Facility Address:	City: _____ Zip Code: _____	E-mail: _____ Website: _____
Food Service Operation Classification : ☐ Bed and Breakfast ☐ Retail Food ☐ Mobile		

OWNERSHIP INFORMATION

Ownership Legal Type: ☐ Association ☐ Corporation ☐ Individual ☐ Partnership ☐ Other _____

Owner's Name: _____ Address: _____ City:_____ ST:____ ZIP :_____	Owner's Phone ( )_____ Owner's Cell Phone ( )_____ Owner's Email _____

MANAGEMENT INFORMATION

Person in Charge has the oversight of a zone, district or region. Name of person in Charge:	Title: _____ Telephone:_____
Operator has oversight of the preparation or serving of food at the establishment. Name of Operator:	Title: _____ Telephone:_____
Enclose copies with application Name(s) of Certified Food Handler(s):	Date of Exam:

The Undersigned Hereby applies for a permit to operate a Food Service Establishment pursuant to Decatur County Ordinance 2006-4. The undersigned hereby attests to the accuracy of the information provided in this application and affirms that the undersigned will comply with the ordinance, and allow the Decatur County Health Official full access to the establishment.

Signature of Applicant(s): _____

Printed Name of Applicant(s): _____

Office Use Only	
Establishment #	Menu Type ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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The following information is REQUIRED. Please return this completed form with page one.

Name of Establishment:_____

Number of Seats_____ Total Square Footage_____

TOTAL Number of Employees_____ Managers_____ Food Handlers_____

Waiters_____ Deliverers_____

Estimated Number of Meals served weekly_____

Meals Served (check all that apply)

Breakfast ☐ Lunch ☐ Dinner ☐ Cater ☐ Mobile Unit ☐

Days and Hours of Operation

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Opening Time							
Closing Time							

********** Please enclose copies of menus and food handler certifications. **********